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February 15, 2008

TO: Each Supervisor

FROM: Bruce A. Chernof, M.D.  
Director and Chief Medical Officer

SUBJECT: **DEPARTMENT OF HEALTH SERVICES (DHS)  
FISCAL OUTLOOK UPDATE AND PHASE I BUDGET  
MITIGATION PLAN [Agenda Item S-3, February 19, 2008]**

Attached for your information is a Summary of Changes in the DHS Fiscal Outlook (Attachments A1-A2) since our last report on October 16, 2007.

Bruce A. Chernof, M.D.  
Director and Chief Medical Officer

John F. Schunhoff, Ph.D.  
Chief Deputy Director

Robert G. Splawn, M.D.  
Senior Medical Director

As indicated in the summary of changes (Attachment A2) the Fiscal Year (FY) 2007-08 year-end balance in the Department's designation fund is \$72.8 million (see line 20 on Attachment A1), an increase from the \$39.8 million per our last update. The cumulative funding shortfalls for FY 2008-09 and FY 2011-12 are estimated to be \$(290.9) million and \$(1,665.8) million, respectively. The developments contributing to these changes are summarized in Attachments A1 and A2.

Over the ten years of the County's 1115 Medicaid Waiver and the subsequent two years of the State waiver, DHS has emphasized ambulatory care, to provide more preventive care in the community and also to attempt to decompress the emergency rooms through reduction of unnecessary visits. For the ten years of the County's waiver, funding was provided which covered some of the costs of providing outpatient care to indigent persons at non-hospital-based clinics. Under the current funding mechanism through a State waiver and a State Plan Amendment, the County receives funding in non-hospital clinics for the cost of treating Medi-Cal patients and Coverage Initiative funding to treat a specified group of indigents. Hospital based inpatient and outpatient costs are much more fully covered by federal revenues, as provided in the State's waiver.

With this context, DHS was asked to develop a budget proposal for FY 07-08, which resulted in a balanced DHS budget, solving it within the department's available resources. The Phase I plan relies upon resolution of several specific and significant revenue issues concerning federal funds, through the state. It also contains \$81 million in cost savings and enhanced revenue within the existing revenue structure, from the County hospitals and care networks. It envisions privatization of most of the DHS health centers, with services provided by community-based providers. It projects a net increase in primary care visits.

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Each Supervisor  
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Service curtailments at the County's hospitals are not proposed, because of several factors. Reduction of beds at County hospitals, particularly until the re-opening of MLK, will make it more difficult to move patients from the emergency rooms into hospital beds, thus congesting the ERs more. In addition, the current State waiver's reimbursement structure, which pays for a much higher percentage of costs in the hospitals, means that more significant reductions would be needed in hospitals to achieve savings in county funding.

The plan allows DHS to concentrate on emergency trauma, inpatient and specialty care, those services most difficult to replace, and links these services with community-based primary care.

If we are not able to achieve resolution of the revenue issues, we will have to move to Phase II, which would include additional reconfiguration and reductions.

Also attached (Attachments B1, B2 and B3) are documents containing the DHS Phase I Health Care Delivery System Reconfiguration and Budget Mitigation Plan.

I will be prepared to discuss these documents at the Board meeting on February 19, 2008. In the meantime, if you have any questions or need additional information, please let me know.

BAC:aw  
fiscal outlook memo 021908 (I)  
609:005

#### Attachments

c: Chief Executive Officer  
County Counsel  
Executive Officer, Board of Supervisors

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES  
SUMMARY OF CHANGES IN THE DHS FISCAL OUTLOOK  
SEPTEMBER 25, 2007 THROUGH JANUARY 31, 2008

		Fiscal Year / Columns / \$ In Millions					
		07-08 / (1)	08-09 / (2)	09-10 / (3)	10-11 / (4)	11-12 / (5)	Total / (6)
(1)	Estimated Cumulative Year-End Fund Balances/(Shortfalls) - 9/25/07 <sup>(A)</sup>	\$ 39.8	\$ (286.0)	\$ (735.2)	\$ (1,193.0)	\$ (1,650.8) <sup>(A)</sup>	\$ (1,650.8)
<b>Adjustments to Reconcile to the FY 2007-08 Final Budget</b>							
(2)	Remove one-time Measure B funds from the Final Budget.	(25.0)	-	-	-	-	(25.0)
(3)	Remove Tobacco Settlement funds that were added to the Final Budget to offset reduced VLF.	(10.8)	-	-	-	-	(10.8)
(4)	Forecast improvement/(reduction) roll-forward	-	(35.8) <sup>(B)</sup>	(35.8) <sup>(B)</sup>	(35.8) <sup>(B)</sup>	(35.8) <sup>(B)</sup>	-
(5)	Adjusted Estimated Cumulative Year-End Fund Balances/(Shortfalls) - FY 2007-08 Final Budget <sup>(A)</sup>	\$ 4.0	\$ (321.8)	\$ (771.0)	\$ (1,228.8)	\$ (1,666.6)	\$ (1,666.6)
<b>Adjustments</b>							
(6)	Adjust estimated MetroCare costs <sup>(C)</sup> .	(9.3)	40.7	68.4	0.7	(0.6)	99.9
(7)	Adjust Cost Based Reimbursement Clinics (CBRC) revenues per 1-24-08 estimates <sup>(C)</sup> .	(10.3)	(3.3)	(12.9)	(21.4)	(21.5)	(69.4)
(8)	Adjust employee benefit costs based on the FY 07-08 estimated actual for historical experiences and inflation factors and extend through FY 11-12. FY 11-12 reflects expiration of pension obligation bond.	9.5	3.4	(7.1)	(10.9)	57.9	52.8
(9)	Adjust FY 11-12 expense base for salary COLA, services from other County departments COLA, services and supplies CPI, and pharmacy CPI, offset by adjustments to the revenue base for Medi-Cal Redesign and CBRC.	-	-	-	-	(38.9)	(38.9)
(10)	Increase nursing salaries related to the new AB 394 ratios effective 1/1/08.	-	(7.4)	(7.4)	(7.4)	(7.4)	(29.6)
(11)	Remove previously estimated Vehicle License Fee (VLF) growth per direction from the CEO.	-	(2.4)	(4.5)	(6.7)	(6.7)	(20.3)
(12)	Refine salary COLAs and services & supplies and pharmacy CPIs based on DHS Budget Request and extend through FY 11-12.	-	(16.2)	(7.1)	2.6	2.6	(18.1)
(13)	Adjust Medi-Cal Redesign revenues based on estimates developed in January 2008 <sup>(C)</sup> .	43.2	(47.7)	(13.8)	16.3	16.7	14.7
(14)	Adjust prior year expense and revenue estimates (one-time adjustment) <sup>(C)</sup> .	12.5	-	-	-	-	12.5
(15)	Increase CHP Equity for FY 07-08 (one-time adjustment).	12.0	-	-	-	-	12.0
(16)	Adjust other revenue estimates (AB 915 Medicaid Outpatient Emergency Services, Medicare, and Medicare Modernization Act (MMA) Section 1011 Program).	7.5	(7.0)	(2.8)	4.7	4.7	7.1
(17)	Adjust LAC+USC order management/document imaging and move transition costs.	1.8	3.4	(2.2)	(8.0)	0.3	(4.7)
(18)	Various other changes per the current year operating forecast received in November 2007 and budget adjustments included in the DHS Budget Request.	1.9	(1.4)	4.1	(1.5)	(0.3)	2.8
(19)	Forecast improvement/(reduction) roll-forward	-	68.8 <sup>(B)</sup>	30.9 <sup>(B)</sup>	45.6 <sup>(B)</sup>	14.0 <sup>(B)</sup>	-
(20)	Revised Estimated Cumulative Year-End Fund Balances/(Shortfalls) <sup>(A)</sup>	\$ 72.8	\$ (290.9)	\$ (725.4)	\$ (1,214.8)	\$ (1,665.8)	\$ (1,665.8)
<b>Potential Solutions</b>							
<b>County</b>							
(21)	Measure B (one-time adjustment)	-	31.0	-	-	-	31.0
(22)	Financial Stabilization	33.6	47.4	26.4	26.4	26.4	160.2
(23)	Forecast improvement/(reduction) roll-forward	-	33.6 <sup>(B)</sup>	112.0 <sup>(B)</sup>	138.4 <sup>(B)</sup>	164.8 <sup>(B)</sup>	-
(24)	Revised Estimated Cumulative Year-End Fund Balances/(Shortfalls) <sup>(A)</sup> & <sup>(B)</sup>	\$ 106.4	\$ (178.9) <sup>(B)</sup>	\$ (587.0)	\$ (1,050.0)	\$ (1,474.6)	\$ (1,474.6)
- after DHS Budget Request and Updated CBRC Revenue Estimates							

ATTACHMENT A1

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES  
SUMMARY OF CHANGES IN THE DHS FISCAL OUTLOOK  
SEPTEMBER 25, 2007 THROUGH JANUARY 31, 2008

		Fiscal Year / Columns / \$ in Millions					
		07-08 / (1)	08-09 / (2)	09-10 / (3)	10-11 / (4)	11-12 / (5)	Total / (6)
(25)	Revised Estimated Cumulative Year-End Fund Balances/Shortfalls						
	- after DHS Budget Request and Updated CBRC Revenue Estimates <sup>(A) &amp; (E)</sup> (cont.)	\$ 106.4	\$ (178.9)	\$ (587.0)	\$ (1,050.0)	\$ (1,474.6)	\$ (1,474.6)
<b>Potential State/Federal Issues</b>							
<b>State</b>							
(26)	State Budget <sup>(F)</sup>	(3.0)	(37.1)	(37.1)	(37.1)	(37.1)	(151.4)
(27)	Coverage Initiative Maintenance of Effort (MOE) <sup>(G)</sup>	-	(31.5)	(31.5)	(31.5)	(31.5)	(126.0)
<b>Federal</b>							
(28)	Adjusting CBRC revenues (hospital only) to include "crossover" patients with dual eligibility on Medicare and Medi-Cal programs	72.8	23.6	24.5	28.2	29.3	178.4
(29)	Pending rule disallowing use of Interns & Residents costs for Certified Public Expenditures	-	(40.3)	(41.5)	(42.8)	(44.1)	(168.7)
(30)	Pending Federal rule limiting Medicaid reimbursement to public hospitals to Medicaid cost <sup>(H)</sup>	-	-	-	(228.0)	(228.0)	(456.0)
(31)	Pending Managed Care Rate Supplement rule limiting public hospitals to managed care costs	-	?	?	?	?	?
(32)	TAR Authorization by Admission	-	?	?	?	?	?
(33)	Forecast improvement/(reduction) roll-forward	-	69.8 <sup>(B)</sup>	(15.5) <sup>(B)</sup>	(101.1) <sup>(B)</sup>	(412.3) <sup>(B)</sup>	-
(34)	Revised Estimated Cumulative Year-End Fund Balances/Shortfalls - after Potential Issues <sup>(A)</sup>	\$ 176.2	\$ (194.4)	\$ (688.1)	\$ (1,462.3)	\$ (2,198.3)	\$ (2,198.3)

**Notes**

- (A) This assumes CBRC will be extended for each year beyond FY 04-05. CBRC extension for LA County's outpatient and clinic care was included in the FY's 05-06 through FY 07-08 Adopted State Budgets. A Medi-Cal State Plan Amendment to extend the program is currently pending CMS approval. FY's 10-11 and 11-12 assume Medi-Cal Redesign 1115 Waiver extension and continuance of its Coverage Initiative component.
- (B) These amounts represent the cumulative change in the forecast from the prior fiscal year. For example, the (\$35.8) million in FY 08-09 is \$4.0 million - \$39.8 million from FY 07-08.
- (C) This reflects MLK being converted to a Multi-service Ambulatory Care Center (MAACC) effective August 15, 2007, and assumes the MAACC to be converted back to a 120-bed hospital on January 1, 2010, as opposed to February 15, 2009 previously estimated.
- (D) This is primarily due to lower than anticipated prior year expense (\$7.4M) and higher than anticipated prior year Insurance revenue (\$1.6M) and Mental Health revenue (\$1.1M).
- (E) DHS Budget Request submitted to the CEO on January 29, 2008 incorporated CBRC revenue estimates developed in December 2007. New estimates were subsequently available on January 24, 2008.
- (F) This reflects estimated financial impact to the County for the following State issues:

	FY 07-08	FY 08-09
Reduction in Medi-Cal provider and managed care rates		
- CBRC reimbursement for outpatient services	\$ 0.9	\$ 11.1
- Managed care payments	0.1	1.6
Reallocation of County funding to fund various State programs		
- Federal Safety Net Care Pool	1.2	14.4
- South Los Angeles Preservation Fund	0.8	10.0
	\$ 3.0	\$ 37.1

(G) DHS is currently working with the California Department of Health Care Services to develop the County's MOE and the related issue of changing our non-hospital based delivery system. DHS will also work with the State to ensure that the Department can fully utilize the administrative components of the Coverage Initiative program.

(H) This reflects the impact of reduced Safety Net Care Pool funds due to limited availability under the pending Federal rule.

(I) This amount reconciles to the DHS Budget Request when adjusted for the following items: Potential additional revenues (Measure B, Tobacco Settlement, etc) to be received and possible service curtailments (\$157.3M); update of FY07-08 operating forecast (\$12.7M); and update of CBRC revenues per the 1-24-08 estimates (\$8.9M).

(J) This amount is computed by taking the difference in FY 10-11 over FY 09-10 (\$1,193.0M - \$735.2M = \$457.8M) and adding it to the Estimated Cumulative Year-End Shortfall of \$1,193.0M (\$1,193.0M + \$457.8M = \$1,650.8M).

### **COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES**

#### **Health Care Delivery System Reconfiguration – Phase I**

In Fiscal Year, 2008-09 the Department projects a funding shortfall of \$290.9 million. In the absence of a funding solution to permanently address the structural deficit, the Department has looked at how to best serve the County's low and moderate-income patients and has developed a recommended plan, which focuses on redirecting resources and is dependent on various revenue options currently being pursued, including those under the control of the County and those for which the Department will need the assistance of the State Department of Health Care Services and the federal Centers for Medicare and Medicaid Services.

The Department is committed to operating a balanced system of outpatient, inpatient, and emergency services. Since 1995, the Department has undergone a restructuring process to provide a more integrated and balanced health care delivery system, expand access to primary and preventive care services, reduce costs and increase efficiencies, and improve clinical care. This proposed plan is a continuation of those efforts presented in the context of the budgetary realities the Department is now facing.

The health care delivery system configuration proposed by the Department is designed to best serve the County patient population within available funding levels. The proposed design is aimed at preserving key elements of the health care delivery system, while supporting the Department's mission to provide health care to indigent patients and maintaining all mandated services.

DHS hospitals and Multi-Service Ambulatory Care Centers (MACCs) would continue to provide services, including outpatient, at current levels. While most DHS Health Centers would be privatized, the Comprehensive Health Centers would be remissioned to emphasize urgent care and specialty care, with specialty care services being expanded. Most primary care visits provided by DHS to indigent patients will be provided by Public Private Partnership (PPP) providers.

The health care delivery system proposed in this document represents Phase I of a reconfigured system. If some of the revenue proposals do not materialize, the Department will need to consider additional reconfiguration of its health care delivery system while assuring that the Department continues to meet its mandate for indigent care.

#### **Health Care Delivery System Configuration – Phase I**

DHS currently serves approximately 700,000 patients annually through three general acute care hospitals, one rehabilitation hospital, two Multi-Service Ambulatory Care Centers, six Comprehensive Health Centers, eleven Health Centers, two school-based clinics, and more than 100 community-based ambulatory care sites where services are provided through the Public Private Partnership Program. Historically, DHS has provided approximately 2.6 million outpatient visits, 275,000 emergency room visits, and 85,000 hospitalizations annually.

The Department is committed to a vision of an integrated and coordinated system of care with a balanced system of inpatient, outpatient and emergency services. The proposed health care delivery system configuration considered the following principles:

- DHS provides a balanced system of outpatient (both primary and specialty), inpatient, and emergency services yet operate within available funding levels.
- DHS is a major and critical provider of inpatient, emergency and trauma services in the County. These services are the most difficult to replace and a reduction in these services would place a tremendous burden on the health care system in Los Angeles County.
- Community-based primary care and the establishment of medical homes is supported.
- DHS provides services as efficiently and cost-effectively as possible to maintain the maximum availability of services.

The recommended Phase I health care delivery system consists of the following:

- Primary Care - Most primary care would be provided through the Public Private Partnership Program. PPP providers are geographically distributed throughout the County, the quality of care at DHS and PPP sites is comparable, and the cost to DHS for primary care visits is less at PPP locations. The PPPs serve as the point of access for primary care and the coordinator of necessary specialty care. With limited exceptions, DHS would no longer directly provide primary care services in most Health Centers and Comprehensive Health Centers and nearly all DHS Health Centers would be privatized to be operated by community providers. The primary care currently provided at the MACCs and hospitals would continue to be provided by DHS at those locations. Access to public health services provided by the Department of Public Health would not be impacted by this plan.

The number of PPP-provided primary care visits would increase from approximately 584,000 visits annually to 850,000 annually. This would result in an expansion of primary care for indigent patients because the increase in PPP-provided primary care visits (up to an additional 266,000 visits annually) would exceed the reduction in primary care directly provided by DHS to indigent patients (232,000 visits annually).

As patients with insurance have more options to obtain primary care from private providers, those who currently use DHS Comprehensive Health Centers and Health Centers for primary care may need to seek care from non-DHS providers.

- Specialty Care – The Comprehensive Health Centers would be remissioned to focus on providing specialty care. The number of specialty care visits provided would increase by approximately 37,500 visits from 180,000 visits annually to 217,500. Some PPP providers would continue to provide specialty care as specified in their contracts. Specialty care services currently provided at the MACCs and hospitals would continue to be provided at those locations.

- Urgent Care – Urgent care visits would remain level at the Comprehensive Health Centers (approximately 161,000 visits annually). Urgent care services currently provided at the MACCs and hospitals would continue to be provided at those locations.
- Emergency and inpatient services would continue to be provided through LAC+USC Medical Center, Harbor-UCLA Medical Center, and Olive View-UCLA Medical Center with trauma services available at LAC+USC Medical Center and Harbor-UCLA Medical Center. It will remain a priority to re-open MLK Hospital with an outside operator, or as a County–operated hospital, to provide emergency and inpatient services. There would be no impact on the inpatient census or number of outpatient visits at DHS hospitals.
- Inpatient and outpatient rehabilitation services would be provided at Rancho Los Amigos National Rehabilitation Center. The solicitation process to identify a potential outside operator for Rancho will continue.
- Trauma Network – There could be an increase in the level of funding for the trauma network.
- Healthy Way LA - The Department's Coverage Initiative program, also known as Healthy Way LA (HWLA), is a health care program that provides non-hospital based health care coverage to low-income uninsured adult legal residents at no cost to the enrollee. The Department is structuring the recommended configuration to maintain these funds.

### **Phase I Impact**

The proposed configuration would impact the Department, its health care delivery system, and the patients it serves. The Phase I configuration could result in a change in the locations where some primary care services are provided, if providers are not identified to partner with in privatizing specific DHS Health Centers. In all cases, the Department would work with PPP providers and patients to facilitate a smooth transition. The goal of privatization is to find an operator for each of the privatized health centers who will continue services on site wherever possible.

The recommended configuration would increase primary care visits for indigent patients. Patients with insurance who currently use DHS Comprehensive Health Centers and Health Centers for primary care may need to seek care from non-DHS providers.

The reconfigured DHS health care delivery system would lead to a reduction in the number of DHS employees. The number of employees that would be impacted depends on the final configuration of DHS facilities and services. The Department is meeting with the Chief Executive Office and Department of Human Resources to develop a workforce reduction plan and options to mitigate the impact. These options include reduction of registry staff, workforce retraining, and placement of employees in other County departments.

## **Next Steps**

The Department is actively pursuing the revenue options to mitigate the funding shortfall and also continuing to identify additional cost savings in the facilities to augment the \$81 million already committed. Because there is not currently a solution that fully addresses the shortfall in DHS' Fiscal Year 2008-09 operating budget, the Department has already begun the necessary planning steps to implement the Phase I health care delivery system configuration consisting of privatizing primary care at Health Centers, expanding primary care visits at PPP provider locations, and remissioning Comprehensive Health Centers to emphasize specialty and urgent care. As part of this planning effort, we propose to initiate discussions with PPP providers concerning their capacity to provide additional primary care visits and their interest in operating County health centers. We will work with the CEO to develop a proposed schedule for a required Beilenson hearing, taking into consideration our progress in achieving revenue mitigations.

**COUNTY OF LOS ANGELES**  
**DEPARTMENT OF HEALTH SERVICES**  
**BUDGET FISCAL YEAR 2008-09**  
(\$ in Millions)

**HEALTH CARE DELIVERY SYSTEM RECONFIGURATION - PHASE I**

**NOT ADJUSTED FOR POTENTIAL IMPACT FROM STATE BUDGET**

Phase I			
Fiscal Year 2008-09 Estimated			
Surplus/(Deficit) <sup>(A)</sup> <sup>(B)</sup>	\$	(290.9)	
CBRC Adjustment <sup>(C)</sup>		96.4	
Adjusted Surplus/(Deficit)	\$	(194.5)	
<u>DHS/COUNTY</u>			
Recapture of 10/16/07 Adjustments to the FY 2007-08 Budget			
Measure B		31.0	
Financial Stabilization <sup>(D)</sup>			
FY 2007-08		33.6	
FY 2008-09		47.3	
Measure B Funds <sup>(E)</sup>		29.0	
Tobacco Settlement Funds <sup>(F)</sup>		15.7	
Privatization			
Health Centers (HC's) (Alphabetical Order)			
Antelope Valley		3.5	
Bellflower		2.6	
Dollarhide		1.2	
Family Medicine (aka Lomita)		6.6	
Glendale		1.9	
La Puente		2.3	
Lake Los Angeles		0.2	
Little Rock		0.2	
San Fernando		6.3	
Vaughn School Base Clinic		0.1	
Wilmington (inc. Gardena SBC)		4.2	
Total HC's	\$	29.1	
Comprehensive Health Centers (CHC's) (Alphabetical Order) <sup>(G)</sup>			
El Monte		9.5	
Hudson		7.9	
Humphrey		8.1	
Long Beach		5.3	
Mid-Valley		7.0	
Roybal		6.0	
Total CHC's	\$	43.8	
Increase to PPPs		25.0	
Increase in Specialty Care Visits		10.0	
Net Reduction from Privatization	\$	37.9	
Total Savings	\$	194.5	
Revised Fiscal Year 2008-09			
Surplus/(Deficit)	\$	-	
	Current System	Proposed	
	Workload	System	
		Workload	Change to Workload
<u>Non-Hospital Based</u>			
Primary Care Visits (Uninsured)	250,516	18,442	(232,074)
Primary Care Visits (Insured)	147,622	10,552	(137,070)
Specialty Care Visits	179,846	217,313	37,467
Urgent Care Visits	161,203	161,203	-
PPP Visits - Primary Care Visits	584,343	850,300	265,957

**Notes:**

<sup>(A)</sup> Includes the transfer of outpatient psych services from LAC+USC to DMH. Does not include the restructuring of the psych services.

<sup>(B)</sup> Does not include the impact of GME costs for the Federal component of Medi-Cal Fee-For-Service, Medi-Cal Outpatient (CBRC) and AB 915. There is currently a Federal moratorium on implementing GME that expires on May 26, 2008.

<sup>(C)</sup> Pending outstanding issue with CMS that will determine if dual eligible Medicare/Medi-Cal costs are eligible for reimbursement under CBRC.

<sup>(D)</sup> Based on actions that DHS is taking to help contribute in minimizing the deficit.

<sup>(E)</sup> In accordance with the Measure B resolution, the Board of Supervisors can increase the amount of Measure B funds by the cumulative increases to the medical component of the Western Urban CPI. The maximum amount of increase to Measure B is approximately \$40.3 million (\$9.75 per average parcel).

<sup>(F)</sup> Tobacco Settlement Funds are "one-time only" funds that are being used to help offset the deficit in FY 2008-09 and forward.

<sup>(G)</sup> The Comprehensive Health Centers will be remissioned for specialty and urgent care services.

### **OUTSTANDING ISSUES**

**Graduate Medical Education Rule (GME)** – CMS maintains that GME is not specifically listed in the Medicaid statute and therefore is not within the scope of medical assistance that is authorized for payment by Medicaid. There is currently a one year moratorium (expires on May 26, 2008) preventing CMS from implementing this proposed GME regulation. We are estimating an annual impact of \$40.3 million. We are currently working with NAPH and CAPH to extend the moratorium an additional year.

**Cost Based Reimbursement Clinics (CBRC)** – In discussions with CMS regarding the extension of the State Plan Amendment for CBRC, CMS is stating that for the extension period Medi-Cal would only pay up to the amount of the Medicare coinsurance and deductible for Medicare/Medicaid crossover patients. Any remaining costs would be unreimbursed. We believe there is a legal basis that Medi-Cal can pay for the associated unreimbursed costs for hospital services to people who are dual eligible. We are currently discussing this issue with the State. The effective date of this issue is July 1, 2005. We are estimating an impact through FY 08/09 at \$96.4 million.

**Coverage Initiative Maintenance of Effort (MOE)** – We are currently working with California's Department of Health Care Services (DHCS) to develop the County's MOE and on the related issue of changing our non-hospital based delivery system.

**TAR Authorization Process** – Currently California's DHCS and CMS are in discussions regarding the renewal of the Superior Systems Waiver. This waiver governs the TAR process for the State of California. We are discussing possible modifications to the current TAR process with DHCS.

**MLK MACC Staffing** - HMA is working with each clinic, at the MLK MACC, to implement the staffing and clinic design recommendations made during the earlier HMA engagement for the MLK MACC. Upon completion, it is expected that the clinics will be able to meet patient workload with fewer staff than is currently assigned. HMA will set staff productivity standards that will be used to manage the clinics over time, so the ones that grow can be staffed up and the ones who shrink can be staffed down as needed.